KAMALA D. HARRIS
Attorney General of California
JAMES M. LEDAKIS
Supervising Deputy Attorney General
MARICHELLE S. TAHIMIC
Deputy Attorney General
State Bar No. 147392
110 West "A" Street, Suite 1100
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 645-3154
Facsimile: (619) 645-2061
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LAN THI PHAN** 9251 Parliament Avenue Westminster, CA 92683 **Registered Nurse License No. 547256** Respondent.	Case No. 2011-887 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 25, 1998, the Board of Registered Nursing issued Registered Nurse License Number 547256 to Lan Thi Phan (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on November 30, 2011, unless renewed.

///

///

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY AND REGULATORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions....

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.
>
> (2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.
>
> (3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

10. On or about May 6, 2009, the Board received a complaint from C.R. of Huntington Valley Healthcare Center (hereinafter "Center"), a skilled nursing facility. The complaint alleged that on March 2, 2009, PATIENT, a resident of the Center, suffered from cardiac arrest but CPR was not initiated nor was 9-1-1 called until requested by the resident's family. When the paramedics arrived, they were not able to resuscitate PATIENT. Respondent was the nurse supervisor on duty. Respondent explained that no resuscitative efforts were undertaken because she believed PATIENT's Advance Directive in PATIENT's electronic chart was "DNR", or "Do Not Resuscitate." However, PATIENT was a full code, as reflected in the Advance Directive in PATIENT's paper chart, which meant the PATIENT was to receive life sustaining measures in the event of an emergency.

11. An investigation was performed by the California Department of Public Health. The investigation revealed the following facts. PATIENT was admitted to the Center on February 9, 2009. He was diagnosed with multiple medical conditions including, acute respiratory failure, septic shock, end stage renal disease and congestive heart failure. A family member was identified as the responsible party. On the Advance Directive, the family member selected the

following option: "I do want CPR". The family member also requested that PATIENT be transferred to the hospital and receive oxygen for comfort.

12. The Center had three licensed vocational nurses at the nurse's station who took care of the patient's basic needs and who supervised the Certified Nurses Assistants. There was one registered nursing supervisor present for each shift. Respondent was the nurse supervisor on duty at the Center on March 2, 2009 during the 3:00 p.m. to 11:00 pm shift.

13. The electronic nursing notes, completed by LVNs K.C. and M.B., for March 2, 2009 revealed that PATIENT was stable at 6:27 am and 3:20 p.m. PATIENT's vital signs were taken at 2:33 p.m. and were within normal limits. PATIENT was assessed at 3:17 p.m., which indicated PATIENT's mental status was unchanged, his breathing was regular and that he had a moist cough that was not productive, his skin was dry and warm and his temperature was 97 degrees. At 5:10 p.m., PATIENT complained of right shoulder pain and was subsequently medicated. About 1 hour later, at 6:05 p.m., PATIENT vomited a brown, thick and foul smelling vomit. Respondent was advised that PATIENT vomited however, there was no documentation that an assessment was performed or that vital signs were taken. According to Respondent, before sending PATIENT to the hospital, she checked PATIENT's Advance Directive in the computer file and believed the asterisk next to "Do Not Resuscitate" meant PATIENT was not to be resuscitated or hospitalized when in fact PATIENT was a full code status and did want life sustaining measures in an emergency situation.

14. At 6:25 p.m., when a CNA was cleaning up PATIENT, PATIENT's condition declined such that he had no blood pressure, no respirations and no pulse. PATIENT's friend, who had been at his bedside, contacted PATIENT's brother in New Jersey. At 6:38 p.m., PATIENT's brother called the Center and asked if the paramedics were called. When advised that the paramedics had not been called, PATIENT brother requested that they be called. The paramedics arrived at 6:40 p.m. No CPR was performed before the paramedics arrived and the paramedics were not called until requested to do so by PATIENT's brother. The paramedics intubated PATIENT and CPR started but at 7:30 p.m., PATIENT was pronounced dead. PATIENT died of cardiac arrest. According to the electronic nursing notes, PATIENT family

and physician were notified of his death. The family member denied being informed of the decline in PATIENT's medical condition.

15. The nursing notes of March 2, 2009 for 6:05 p.m., 6:25 p.m. and 6:40 p.m. were edited. Respondent admitted that she and LVN M.B. edited the nursing notes. The editions are as follows:

a. Notes for 6:05 p.m.:

i) Original note created by LVN M.B. states:

> ...resident had episode of emesis, brown colored, thick, foul odor, family at bedside (friend Richard). According to advanced directives, resident is no CPR, DNR, no acute hospital transfer, friend is aware of condition, he will call the family to inform of condition. Feeding turned off due to emesis, will continue to monitor condition.

ii) The edited note by LVN M.B. on March 2, 2009 at 7:12 p.m. omits the information regarding the Advance Directive and states:

> ...resident had episode of emesis, brown colored, thick, foul odor, family at bedside (friend Richard), friend is aware of condition, he will call the family to inform of condition. Feeding turned off due to emesis, will continue to monitor condition.

b. Notes for 6:25 p.m.:

i) Original note created by LVN M.B. on March 2, 2009 states:

> ...resident was cleaned by CNA for emesis, cleaned and kept dry, HOB elevated 45 degrees to prevent aspiration, condition has declined with no b/o, no respirations, no pulse, checked by two nurses. MD informed, friend is aware and left message for brother, friend will call back.

ii) First edited note by LVN M.B. on March 2, 2009 at 7:38 p.m. omits the information regarding the decline of PATIENT's condition and states:

> ...resident was cleaned by CNA for emesis, cleaned and kept dry, HOB elevated 45 degrees to prevent aspiration, MD informed, friend is aware and left message for brother, friend will call back.

ii) Second edited note by LVN M.B. on March 3, 2009 at 5:20 p.m. adds the underlined information:

> ...resident was cleaned by CNA for emesis, cleaned and kept dry, HOB elevated 45 degrees to prevent aspiration. MD informed. Friend/Richard/Emergency contact, at bed site, who wanted to notify the brother who live *[sic]* out of state in New Jersey 18:38 Brother returned call, informed to *[sic]* brother of Patient's condition, Brother requested to call paramedic to evaluate.

c. Notes for 6:40 p.m.:

i) Original note by LVN M.B. states:

911 call, Paramedic arrived, intubation and CPR started

ii) Edited note by LVN M.B. on March 3, 2009 at 5:27 p.m. added the underlined information:

911 call. Paramedic arrived, Resident was assessed by paramedics and they intubation [sic] and started CPR, After approximately 30 mins, Resident non responsive to treatment and was announced dead after a long attempt of intubation and CPR. Paramedics stated that resident had a cardiac arrest, RN supervisor informed and will notify family.

16. PATIENT's physician denied being informed of the decline in PATIENT's condition and was only informed after PATIENT's demise.

17. Respondent was terminated from the facility on or about April 6, 2009 for failing to appreciate a resident's full code status, misrepresenting facts surrounding the incident to her supervisor when questioned, failing to document sufficient information in the chart surrounding the incident and charting under another nurse's name in the electronic record removing important information.

FIRST CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to disciplinary action under Code section 2761(a)(1) in conjunction with title 16, California Code of Regulations, sections 1443 and 1443.5 in that Respondent lacked possession of or failed to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse when:

a. Respondent did not suspect PATIENT was having a heart attack despite the presence of vomiting and shoulder pain, as more fully set forth in paragraphs 10-17 above, and incorporated herein as though set forth in full;

b. Respondent failed to review PATIENT's paper chart, in addition to the electronic chart, for the Advance Directive. The Advance Directive in the paper chart showed PATIENT's code status was a full code and not a "DNR" as Respondent erroneously believed, as more fully set forth in paragraphs 10-17 above, and incorporated herein as though set forth in full; and,

c. Respondent did not know where to find the code status in the computerized version of the patient record, as more fully set forth in paragraphs 10-17 above, and incorporated herein as though set forth in full.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to disciplinary action under Code section 2761(a) for unprofessional conduct in that:

a. Respondent made editions in PATIENT's electronic chart that altered documentation of a sentinel event, as more fully set forth in paragraphs 10-17 above, and incorporated herein as though set forth in full.

b. Respondent failed to follow the protocol for contacting PATIENT's physician or his alternate when there was a change in PATIENT's condition, as more fully set forth in paragraphs 10-17 above, and incorporated herein as though set forth in full.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 547256, issued to Lan Thi Phan;

2. Ordering Lan Thi Phan to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 4/27/2011

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SD2011700204/10687420.doc